

PERCEPTIONS OF SURGICAL PATIENTS: A COMPARATIVE STUDY
OF CLASS PERCEPTIONS TO IMMINENT GENERAL SURGERY

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CHAPTER I

INTRODUCTION

The emphasis in nursing today is on individualized patient care. The way a patient perceives his hospital experience has a bearing on both his psychological and physiological adjustment to the situation. If the concept of individualized nursing care is to be actualized for nurses who care for surgical patients, it will be necessary to understand what surgery means to the individualized patient and to know how the patient perceives what is happening to him.

Every patient brings with him to the hospital setting a unique background of experience and perception. Woodruff defines perception as a person's experiences in the world and how these experiences register within him in the form of skills, habits, feelings, values, and concepts.¹ Perceptions affect behavior toward situations in one's environment and are, in turn, affected by the environment. A person's perceptions are responsive to conditioning, reward and punishment, and to social forces.

Studies have long shown that the social class with which one is identified is a major determinate of that

¹Asahel Woodruff, Basic Concepts of Teaching (San Francisco: Chandler Publishing Co., 1961), p. 88.

individual's decisions and his social actions. Every major area of American life appears to be directly or indirectly affected by social class structure.² Members of different social classes, by virtue of experiencing different conditions of life, come to see the world differently-- to develop different conceptions of social reality, aspirations, hopes and fears, and "conceptions of the desirable."³

Assuming that one's perception of an experience is affected by his position in the social order, then this perceptual background could effect how this person as a patient experiences the stressful situation of surgery. Because surgery is recognized as being a psychologically and physiologically stressful experience, the care of the patient must be directed toward preparing him mentally and physically for the surgical event from his own point of view.⁴ To do this, one must have knowledge of how the patient defines his situation. Nurses who assume they know how a patient is perceiving his experience are frequently incorrect.

²W. Lloyd Warner, Marchia Meeker, and Kenneth Eells, Social Class in America (Chicago: Science Research Associates, 1949), p. 6.

³Melvin L. Kohn, Class and Conformity: A Study in Values (Ontario: The Dorsey Press, 1969), p. 7.

⁴Rhetaugh G. Dumas, Barbara J. Anderson, and Robert C. Leonard, "The Importance of the Expressive Function in Preoperative Preparation," in Social Interaction and Patient Care, ed. James K. Skipper and Robert Leonard (Philadelphia: J. B. Lippincott, 1965), p. 19.

Statement of the Problem

Recently a great deal of work has been done on the psychological and physiological care of preoperative and postoperative patients. At the present time, there is growing evidence that social class affects a patient's perception of the operative experience and of what is happening to him during this time. This aspect of the total surgical experience has not been explored in sufficient depth.

Purpose of the Study

The purpose of this study is to compare the expressed perceptions of lower middle class, working class, and lower class individuals to general abdominal surgery.

Hypotheses

1. There is no difference in the perceptions of subjects toward imminent general surgery according to their social class position.
2. No difference in perception of imminent general surgery occurs because of age difference.
3. No difference in the perception of imminent general surgery exists between male and female subjects.

Assumptions

Because the following statements have been shown in previous studies to be correct, this investigator has

utilized them as a basis for the development of this study.

1. Surgery is a psychologically stressful experience.⁵
2. Social class standing affects perceptions.⁶
3. Preoperative surgical patients can verbalize their perceptions of experiences utilizing the Palmer Patients' Perception Scale.
4. Hollingshead's Two Factor Index of Social Class is an accurate means of differentiating between lower middle class, working class, and lower class groups.

Limitations

This investigator has realized that the following are limitations to the application of the study.

1. The population of the study is small and limited to literate lower middle class, working class, and lower class adults; therefore, findings of the study cannot be applied to populations outside of the study population.
2. The study does not include an interpretation of patient responses, nor does it attempt to explore the reason for responses. It compares the expressed perceptions of

⁵I. Janis, Psychological Stress: Psychoanalytic and Behavioral Studies of Surgical Patients (New York: John Wiley and Sons, 1958), p. 8.; David T. Vernon and Douglas Gigelow, "Effects of Information About a Potentially Stressful Situation on Responses to Stress Impact," Journal of Personality and Social Psychology 29 (January 1974): 50-59.

⁶Kohn, Class and Conformity, p. 7; Warner, Social Class in America, p. 6.

adult general surgery patients; therefore, this is the only type of data that should be expected.

Definitions

For the purposes of the study the following terms have been defined:

1. Social class: An aggregate of individuals who occupy broadly similar positions in a hierarchy of power, privilege, and prestige.⁷ Patients are placed in a social class position using the Hollingshead Two Factor Index of Social Position.⁸ (See Appendix A, page 62.)
 - a. Lower middle class: Those persons meeting the criteria for Class III.
 - b. Working class: Those persons meeting the criteria for Class IV.
 - c. Lower class: Those persons meeting the criteria for Class V.
2. General Abdominal Surgery: A major surgical procedure requiring general anesthesia on patients admitted to the general surgery service. The procedures selected

⁷ Robin M. Williams, Jr. American Society: A Sociological Interpretation (New York: Knopf, Inc., 1960), p. 98.

⁸ August Hollingshead, Two Factor Index of Social Position (New Haven, Connecticut: printed privately, 1957), p. 1.

for the study are cholecystectomy, gastrectomy, and abdominal herniorrhaphy.

3. Patient: Any adult individual admitted to the general surgical service for cholecystectomy, gastrectomy, or abdominal herniorrhaphy.

4. Perception: A process of information extraction.⁹

Perception may be further understood as

The mental mechanism by which the nature and/or meaning of a sensory stimulus or aggregate of stimuli is recognized. It occurs through the use of the senses to integrate and interpret past experiences in response to present stimulus.¹⁰

Justification for the Study

According to Janis, a person's social background influences the way in which a painful experience is perceived and assimilated. This social background appears to determine to some extent whether or not the person will admit his potential losses, whether he will freely express his emotional agitation or try to keep it from others, and whether he will have high or low confidence in the protective capabilities of others.¹¹

⁹Ronald H. Forgas, Perception (New York: McGraw-Hill Book Co., 1966), p. 1.

¹⁰American Psychiatric Glossary (Washington: Committee on Public Information, American Psychiatric Association, 1964), p. 56.

¹¹Janis, Psychological Stress, p. 9.

It is hoped this study, which is an adaptation of a study done by Dr. Irene Palmer in 1963, will enlarge the knowledge of socio-cultural aspects in the care of patients. Increased knowledge of such factors may encourage nurses to be more aware of the individual patient's perceptions of his surgical experience.

CHAPTER II

REVIEW OF LITERATURE

The purpose of this study was to compare the expressed perceptions of adult patients to general abdominal surgery according to their membership in the lower middle class, working class, and lower class. In the interest of achieving this purpose, this investigator reviewed literature concerning preoperative and postoperative care; surgery as a stressful situation; and, social class structure.

Preoperative and Postoperative Care

A patient entering the operating room for a major surgical procedure is probably embarking upon one of the most significant and potentially threatening experiences of his life. His chances for an uneventful recovery depend a great deal on the adequacy of his preoperative care.¹

There has been an emphasis in the literature on the responsibility of the professional nurse to provide continuity of care in a medical environment which consists of a number of specialized and fractionalized services. It has been

¹Rhetaugh G. Dumas, Barbara J. Anderson, and Robert C. Leonard, "The Importance of the Expressive Function in Pre-operative Preparation," in Social Interaction and Patient Care, ed. James K. Skipper and Robert Leonard (Philadelphia: J. B. Lippincott, 1965), p. 18.

shown that a strong relationship exists between psychological preparation with continued support during the preoperative period and reduction of stress, as measured by the patient's postoperative psychological responses. These studies have used a variety of physiological measures and indexes of postoperative conditions, such as postoperative vomiting, amount of narcotics, analgesics, and sedatives requested; vital signs; urinary retention; and length of hospitalization.²

Other studies have reached similar conclusions about the beneficial results of psychological preparation using interviews, self-reports by patients, and clinical care studies of individual patients.³ As a result, the kinds of communication given a patient about his surgery have been stressed as crucial in the patient's over-all behavioral response.

²Rhetaugh Dumas and Robert Leonard, "The Effect of Nursing on the Incidence of Postoperative Vomiting," Nursing Research 12 (Winter 1963): 12-15; L. D. Egbert, et al., "Reduction of Postoperative Pain by Encouragement and Instruction of Patients," New England Journal of Medicine 270 (April 16, 1964): 825-827; K. Healy, "Does Preoperative Instruction Make a Difference?," American Journal of Nursing 68 (January 1968): 62-67; Jean E. Johnson, "Effects of Structuring Patients' Expectations on Their Reactions to Threatening Events," Nursing Research 21 (November-December 1972): 499-503; C. A. Linderman, "Nursing Intervention with the Presurgical Patient; Effectiveness and Efficiency of Group and Individual Preoperative Teaching: Phase Two," Nursing Research 21 (May-June 1972): 196-209.

³I. Janis, Psychological Stress: Psychoanalytic and Behavioral Studies of Surgical Patients (New York: Wiley and Sons, 1958), pp. 58-62; J. R. Cassidy and John Altrocchi, "Patient Concerns About Surgery," Nursing Research 9 (Fall 1960): 219-221; D. L. Carnevali, "Preoperative Anxiety," American Journal of Nursing 66 (July 1966): 1536-1538.

Two general theoretical positions on the relationship between preoperative fear and anxiety and postoperative recovery can be found in the literature. The most commonly held is the position that there is an inverse relationship between the preoperative level of fear and postoperative recovery and adjustment. The greater the fear and apprehension, the poorer the recovery. Clinical studies based on this view attempt to reduce or minimize high levels of anxiety with some type of special preoperative psychological preparation. The procedure is evaluated in terms of one or two criteria for measures of postoperative recovery such as reduction of postoperative vomiting and a lowered need of pain medication.⁴

The other position, strongly supported by Janis, demonstrates a curvilinear relationship between preoperative fear levels and postoperative welfare and adjustment. Both high and low levels of fear were associated with more difficult postoperative convalescence.⁵

The importance of the meaning of the hospital experience to the patient is recognized, but in practice there is a tendency to assume knowledge of the patient's point of view. Hospital personnel tend to act on the assumption that what is important, dangerous, or discomforting to them has the same

⁴Dumas, "Effect on Vomiting," pp. 12-15; Egbert, "Reduction of Pain," pp. 825-827.

⁵Janis, Psychological Stress, p. 217.

effect on the patient. This can result in well-meaning but ineffectual attempts at psychological preparation and supportive reassurance.⁶

Carnivali asked ten preoperative patients to state causes of their anxiety and to rate their responses from most to least causative. She then compared these ratings with those given by the patients' nurses. The two sets of answers were often quite different.⁷ Nurses accurately perceived the patients' fear of the unknown and their concern over separation from home, but they did not identify their patients' fears of pain, death, and destruction of body image.

Because the surgeon, anesthesiologist, and nurses share similar values, they tell the patient about aspects of surgery that are important to themselves as professionals in the performance of their own roles. They find little reason to doubt that their values should not be shared by the patient. Unless efforts are focused precisely on what the patient is experiencing, doctors and nurses will be offering nothing more than "pat reassurances" and platitudes, which will not accomplish the purpose intended--to

⁶Dumas, "Importance of Expressive Function," p. 19.

⁷Carnivali, "Preoperative Anxiety," pp. 1536-1538.

prepare the patient for surgery.⁸

Through his survey of seventy-seven male college students who had undergone major surgery, Janis demonstrated that patients with a clear understanding of what to expect exhibited a much lower degree of stress preoperatively and postoperatively than those patients who were poorly prepared.⁹ Because the patient's adequate understanding of facts related to his case seems to be the key to his receiving more effective care, it would appear that informing the patient of these facts would convey that understanding. But even when the necessary information is given, the patient is not always able to accept or understand it. Fear of a particular disease, intellectual level, or emotional and attitudinal factors may cause a patient to forget, distort, or deny having been given the information.¹⁰

A person's desire for information forms a potent variable in determining what information he will receive and how he will interpret it. Understanding is facilitated when the individual receives the kind of information that he feels he needs in a particular situation. Conversely, communication is

⁸Rhetaugh Dumas, "Psychological Preparation for Surgery," American Journal of Nursing 63 (August 1963): 52-55.

⁹Janis, Psychological Stress, pp. 352-360.

¹⁰Joan Dodge, "Factors Related to Patients' Perceptions of Their Cognitive Needs," Nursing Research 18 (November-December 1969): 502.

impaired when an individual regards a particular message as not sufficiently important to attend to or, even worse, when he rejects it.¹¹ Sex, education, and the nature of the surgical involvement are factors related to some of the information patients feel is important to be told.¹²

Emotions affect bodily functions, and it is important that all medical and surgical personnel are aware of this fact. These emotions are tied to the patient's life outside of the hospital. Patients are not just physically ill people. They are also high school graduates, parents, housewives, apartment or house dwellers, who have dreams and hopes for the future. This background plays a part in the patient's perceptions of and response to the hospital environment.¹³

Fear of pain, of the unknown, and of being suddenly dependent is common in almost every preoperative patient. The greatest fear appears to be of the unknown. The preconceived ideas formed from information by friends, neighbors, magazines,

¹¹J. L. Freedman and D. O. Sears, "Selective Exposure," in Advances in Experimental Social Psychology ed. Leonard Berkowitz, 3 vols (New York: Academic Press, 1964), 2: 53-95; P. H. Tannenbaum, "Congruity and Persuasion" in Advances in Experimental Social Psychology ed. Leonard Berkowitz, 3 vols. (New York: Academic Press, 1967), 3: 272-318.

¹²J. S. Dodge, "How Much Should the Patient Be Told and by Whom," Hospitals 37 (December 1963): 66-79.

¹³Minna Field, Patients Are People (New York: Columbia University Press, 1967), pp. 3-4.

and newspapers all tend to distort and exaggerate the facts.¹⁴

Borkowski and Mann demonstrated that anxiety can influence short-term memory. As anxiety increases, one's awareness of the environment decreases, the perceptual field narrows, and one becomes less receptive to environmental cues.¹⁵ This suggests that the ability to recall items about surgical experiences can provide an indirect measure of anxiety at that time. Patients who are experiencing a high degree of anxiety tend to direct their energies inward, and their perceptions of external events tend to be minimized.

Accurate expectations about the physiological sensations a patient will experience can reduce his distress during confrontation with a threatening event such as surgery.¹⁶ Patients who have the knowledge and the ability to participate in their recovery will experience less anxiety and recover more smoothly knowing they have some control over themselves and their situation.

Meyers suggested that if a patient is given specific information upon which to structure an impending event, he can decrease tension and aid in his own comfort.¹⁷ Informing the

¹⁴Dole C. Levine and June P. Feilder, "Fears, Facts, and Fantasies About Preoperative and Postoperative Care," Nursing Outlook 18 (February 1970): 352-354.

¹⁵J. G. Borkowski and T. Mann, "Effects of Anxiety and Interferences on Short-Term Memory," Journal of Experimental Psychology 78 (October 1968): 352-354.

¹⁶Johnson, "Effects of Structuring Expectations," p. 500.

¹⁷Meyers, M. E. "Effects of Communication," pp. 126-131.

patient of what is going to happen to him can assist him in tolerating the stressful events of hospitalization. However, the information provided should be that which the patient needs in order to behave successfully. This is not necessarily the technical information required by the hospital staff. Studies have shown that surgical patients who were told of anticipated unpleasant experiences and led to expect that they could take action to influence what happened during these experiences had shorter hospital stays than patients who were not given such information.¹⁸

The "work of worry" is a process of searching for useful defenses against a danger. When patients are forewarned of dangers to be overcome during the post-operative period, reflective fear is aroused. This stimulates the patient in the "work of worry" which, in turn, prepares him to cope psychologically with the danger.¹⁹ Janis suggests that a moderate amount of preoperative fear leads to optimum postoperative emotional adjustment, while extremely low or extremely high preoperative fear interferes with adjustment.²⁰ The fund of factual and supportive information

¹⁸ Egbert, "Reduction of Postoperative Pain," pp. 325-327; Healy, "Preoperative Instruction," pp. 62-67.

¹⁹ Jean Johnson, James Dobb, Jr., and Howard Leventhol, "Psychosocial Factors in the Welfare of Surgical Patients," Nursing Research 19 (January-February 1970): 18-29.

²⁰ Janis, Psychological Stress, p. 217.

given persons in stress situations has been considered of central importance in the subsequent behavioral response.

In the surgical situation, it is the nurse who is in the best position to clear the patient's "perceptual field."²¹ The nurse must be able to determine the patient's perception of his situation and its meaning for him. The nurse must be able to identify and fulfill those patient needs that will facilitate the prevention, mitigation, or alleviation of stress. According to Dumas,

Patients must be assisted to verbalize their feelings, attitudes, concerns, and expectations with regard to their present or anticipated situation. They must be helped to accurately assess their situations and to develop realistic attitudes and expectations. They must be aided to cope effectively with, or maintain a high tolerance for, the disquieting internal and external stimuli that may characterize the immediate situation.²²

If the medical personnel could understand the feelings expressed by their patient and the motivations behind patient's behavior, not only would the personnel be more comfortable in their situation, but also a real contribution to patient care and recovery would result.²³

²¹D. W. Giller, "Some Psychological Factors in Recovery From Surgery," Hospital Topics 41 (July 1963): 33.

²²Dumas, "Importance of Expressive Function," p. 197.

²³Lewis Bernstein and Richard Dana, Interviewing and the Health Professions (New York: Appleton-Century-Crofts, 1970), p. 20.

To meet the patient's psychological needs consistently, the nurse must understand how each patient is experiencing his particular situation. She must then be able to use this information as a basis for highly personalized, properly timed, and precisely focused nursing action.²⁴

Surgery as a Stressful Situation

It is a generally accepted theory that the threat of a surgical operation constitutes a truly potent source of stress for almost everyone. The surgical setting is said to reactivate numerous childhood conflicts and needs in people who are about to undergo surgery.²⁵ Surgery confronts the patient with real and imagined dangers, many of which, such as pain or discomfort, the possibility of permanent damage, and the danger of death, have had deep meaning throughout the patient's life. The threat of surgery, along with the necessary conditions under which it takes place, renews fears, attitudes, and thoughts which must be dealt with by all who care for the surgical patient.

Stress studies have involved psychologists in a search for more effective ways to help patients deal with very stressful events in their lives. Lazarus and Alfert focused on changing the meaning of the stress, hence making it seem less

²⁴ Lunas, "Importance of Expressive Function," p. 198.

²⁵ Giller, "Some Psychological Factors," p. 13.

threatening and reducing the experienced stress.²⁶ Janis emphasized the process of "rehearsal" by which the individual practices mastering the stress.²⁷ Egbert et al. prepared forty-six patients for the stress of surgery by means of a careful and continuing process of rapport building with information given by the patients' anesthesiologist. These individually instructed patients needed less medication and were sent home earlier than the fifty-one unprepared patients used as a control.²⁸ Taking a different approach, Andrew used a sentence-completion test to divide fifty-nine hospitalized veterans into three personality types. She focused her study on the different means of dealing with stress such as intellectualizing versus avoiding. She hypothesized that patients who accepted information about impending stress would reduce their stress and recover more quickly than those patients who avoided information.²⁹

Deutsch was one of the first to provide a theoretical model of psychological reactions to surgery. Working within

²⁶R. S. Lazarus and E. Alfert, "Short-circuiting of Threat by Experimentally Altering Cognitive Appraisal," Journal of Abnormal and Social Psychology 69 (July 1964): 195-205.

²⁷Janis, Psychological Stress, pp. 301-315.

²⁸Egbert, "Reduction of Postoperative Pain," pp. 825-827.

²⁹June Andrew, "Recovery From Surgery, With and Without Preparatory Instructions for Three Coping Styles," Journal of Personality and Social Psychology 15 (July 1970): 223-226.

a psychoanalytical framework, she postulated that the arousal of fear and anxiety is central to the building up of inner defenses and that before the operation the patient undergoes a period of inner preparation in which he attempts to defend against the aroused anxiety.³⁰

Deutsch believed that to understand what the "inner assimilation" of anxiety means in the individual case, it is necessary to know the nature of the person's fear. Deutsch's psychoanalytic model was a precursor to Janis's extensive studies of psychological reactions to surgery which classified patients' responses on the basis of their level of fear.³¹

The severity of the reaction to the particular stress of impending surgery seems to depend, in part, upon the personality characteristics, previous mastery of stressful conditions, and the perceptions of the surgery which the patient gains during the preoperative preparation.³²

Kaplan studied the emotional impact of diagnostic laboratory tests such as EEG's, EKG's, and X-rays. He found that adverse emotional responses were common. The major causes found for the reactions included lack of information or mis-

³⁰H. Deutsch, "Some Psychoanalytic Observations in Surgery," Psychosomatic Medicine 4 (January 1942): 105-115.

³¹Janis, Psychological Stress, pp. 398-412.

³²Ibid., p. 217; B. Meyer, "Some Psychiatric Aspects of Surgical Practice," Psychosomatic Medicine 20 (January 1968): 3.

information regarding the procedure, strangeness of the environment in which the test was performed and of the personnel conducting the test, fear of learning about an undiagnosed serious disease, and the nature of the patient's basic personality structure.³³

Speisman found that a person's basic personality as shown by the Minnesota Multiphasic Personality Inventory (MMPI) scales is an important determinant of stress reactions when he studied reactions of people to an anxiety-producing film.³⁴ He found that the interpretation of a stimulus depends, in part, on the beliefs or expectations a person has about the stimuli and its consequences.

Any new event experienced by an individual arouses tension and the person subjected to the stress employs various devices to assist in reduction of the tension. Basic to the tension reduction is the need to attach some meaning to the event in order to give it some cognitive structure. Because of underlying attitudes and personality differences, the structuring process will differ for each person. For some people, factual information or actual past experience may provide sufficient meaning.

³³S. M. Kaplan, "Laboratory Procedures as an Emotional Stress," Journal of the American Medical Association 161 (June 23, 1956): 677-681.

³⁴J. C. Speisman, R. S. Lazarus, A. Mordkaff, and L. Davidson, "Experimental Reduction of Stress Based on Ego Defense Theory," Journal of Abnormal and Social Psychology 68 (April 1964): 367-380.

For others, the structuring they use may be based on stereotypes.³⁵

Johnson used the above two methods to examine patients' experiences during threatening events. Patients often asked for information about the impending event. They sometimes reported that what they experienced had been quite different from what they had expected. Their reports suggest that they had sought information from which to form expectations about the impending event and then compared the expectations with the experience. The discrepancy between expectations and experience resulted in an unpleasant emotion. The greater the discrepancy between expectations and the experience, the greater the unpleasant feelings.³⁶

Surgery, in particular, is a situation which makes heavy demands on a person's adaptive powers. The need to maintain a clear "perceptual field" that is reality oriented is a potent problem for one faced with a situation that threatens to re-activate numerous deep-seated childhood conflicts.³⁷

Janis offers one critical explanation of his findings concerning the poor recovery group. He suggests that accurate perception and reality testing were not maintained during the

³⁵ M. E. Meyers, "Effects of Types of Communication on Patient's Reaction to Stress," Nursing Research 13 (Spring 1964): 126-131.

³⁶ Johnson, "Effects of Structuring Expectations," p. 499.

³⁷ Giller, "Psychological Factors," pp. 85-86.

preoperative period; consequently, the subjects faced a period of surprise and personal "victimization" regarding their surgery and this, in turn, greatly hindered recovery.³⁸ Maintaining a reality based perception of events around him appears to be a problem of the surgical patient.³⁹

Whether or not a particular situation causes stress depends a great deal upon the way the individual perceives the situation. Man reacts not only to the actual existence of danger, but also to the perceived threats and symbols of danger from the past.⁴⁰

In the course of becoming a patient, many people encounter numerous puzzling and potentially threatening situations. They are deprived of many of their customary rights, satisfactions, and symbols of status, in addition to being subjected to pain and discomfort. Infrequent, vague communications with professional personnel, the organic sensations, restricted body functions, and enforced hygienic routines are often misinterpreted by patients. These and other similar experiences strain the patient's adjustive capabilities.⁴¹

³⁸Janis, Psychological Stress, pp. 143-147.

³⁹Giller, "Psychological Factors," pp. 85-86.

⁴⁰Rhetaugh Dumas, "Utilization of a Concept of Stress As a Basis for Nursing Practice," in ANA Clinical Sessions: San Francisco 1966 (New York: Appleton-Century-Crofts, 1967), p. 196.

⁴¹Janis, Psychological Stress, p. 367.

The degree to which the experience constitutes a stress, however, will vary from patient to patient. It will depend to a large extent upon how he perceives his illness, treatment, the hospital environment, the functions and responsibilities of hospital personnel, and upon what he feels the personnel will require of him. The patient's reaction to the surgical experience may also be influenced by some home situation that is related to the illness.⁴²

Conditions of stress frequently create perceptual distortions which interfere with one's ability to make an accurate assessment of reality; thus, even though relevant information is available, it may not be sought because its need is not recognized. An individual may also concentrate on irrelevant details which provide him with a feeling of pseudo confidence and relieve him of the need to face the main problem. People perceive and respond to a situation in the way they consider appropriate.⁴³

Implicit in studies is the principle that stress must first be perceived, then interpreted in the context of prior experience and, finally, if the stress is indeed read as a real threat, be confronted by those unique psychological

⁴²Rhetaugh Dumas, "Psychological Preparation for Surgery," American Journal of Nursing 63 (August 1963): 52-55.

⁴³Joan Dodge, "Factors Related to Patient Perceptions of Their Cognitive Needs," Nursing Research 18 (November-December 1969): 502.

barriers we term ego defenses. For most stressful situations, there will be enough variability in perception, interpretation, and defensive effectiveness so that a broad range of psychological and psycho-physiological responses can be anticipated in any large group of human subjects.⁴⁴

Social Class Structure

The concept of social class is one with distasteful connotations to equalitarian-minded Americans, and one whose sociological meaning is often poorly understood. Even sociologists have difficulty agreeing on a single definition. Generally, though, social class is considered to refer to a system of ranking that is associated with economic life.⁴⁵

Introduction of the social class concept does not imply a mechanistic formula by which persons within a given sociological grouping are observed as invariably similar, regardless of unique events in their lives, individual qualities of family relationships, and biological heredity. Studies of the class concept investigate only the probability that people

⁴⁴J. L. Katz, H. Weiner, T. F. Fallagher, L. Hellman, "Stress, Distress and Ego Defenses: Psychoendocrine Response to Impending Breast Tumor Biopsy," Archives of General Psychiatry 23 (August 1970): 131-142.

⁴⁵M. Gordon, Social Class in American Sociology (New York: McGraw Hill Book Co., 1963), p. 10.

of a given group are more likely to exhibit certain characteristics.⁴⁶

According to Kahl, a tendency exists for persons within each social class to become similar to each other and distinct from other social class strata. In other words, the various stratification variables tend to merge and form a pattern. It is this pattern that creates social classes.⁴⁷

Scholars have long been fascinated by the division of society into classes of strata based on variations in wealth, power, or prestige. American society is made up of a wide variety of economic positions despite its egalitarian ideology, its belief in the existence of a greater opportunity for social mobility here than in other countries, and its lack of class consciousness. Location in the economic spectrum affects many aspects of social behavior and life opportunities.⁴⁸ Variations in life styles, mating and sexual behavior, and child-rearing customs, have all been linked to socioeconomic

⁴⁶Allan Grey, "Social Class and the Psychiatric Patient: A Study in Composite Character," Contemporary Psychoanalysis 2 (Spring 1966): 87-121.

⁴⁷J. Kahl, The American Class Structure (New York: Rinehart and Co., 1957), pp. 11-13.

⁴⁸Ruth Elder and Roy Acheson, "New Haven Survey of Joint Diseases XIV: Social Class and Behavior in Response to Symptoms of Osteoarthritis," Milbank Memorial Fund Quarterly 48 (October 1970): 449-502.

or social class position.⁴⁹

For the general population, social class level predicts the groupings from which people tend to choose their friends and much about their attitudes, values, and behavior. Social class is correlated with such diverse phenomena as use of leisure time, educational opportunities, voting behavior, fertility, community power, crime rate, marriage patterns, and political participation. In other words, social class is an important determinant of "one's very life chances."⁵⁰

The evidence indicates that responses to illness and receipt of medical care are also influenced by position in the social stratification system, although the data available are not always consistent.⁵¹ Contradictory findings may be due, in part, to a lumping together of a wide range of diseases. According to Elder, there is a need for more specific infor-

⁴⁹R. Bendix, S. M. Lipset, ed., Class, Status, and Power: A Reader in Social Stratification (New York: The Free Press, 1960), p. 89; U. Brofenbrenner, "Socialization and Social Class Through Time and Space," in Readings in Social Psychology ed. E. Maccoby (New York: Holt, Rinehart, and Winston, Inc., 1958), pp. 400-425; M. Kohn and C. Schooler, "Class, Occupation, and Orientation," American Sociological Review 34 (October 1969): 659-678.

⁵⁰J. L. Myers and B. M. Roberts, Family and Class Dynamics in Mental Health (New York: John Wiley and Sons, Inc., 1959), pp. 27 and 250.

⁵¹S. King, Perceptions of Illness and Medical Practice (New York: Russell Sage Foundation, 1962), p. 103; J. Myers and L. Bean, A Decade Later (New York: John Wiley and Sons, Inc., 1968), p. 20; Saxon Graham, "Socioeconomic Status, Illness, and the Use of Medical Services," Milbank Memorial Fund Quarterly 35 (January 1957): 53-66.

mation about different types of health and illness situations in order to clarify the conditions under which social class does or does not have an effect.⁵²

In pointing out the importance of knowledge of the impact of social class position on health, Parsons stated that education and health are fundamental to achievement because they condition the individual's capacity to exploit whatever opportunities society has to offer.⁵² According to Ross, the traditional relationship between social class and the behavior of people with some type of health problem is: the higher one's income, education and occupation, the less indifference to symptoms and the greater use of medical care.⁵⁴ Koos' work fully supports this view.⁵⁵

In a study of 550 families in a small town in southern New York, Koos found that almost all aspects of health and illness behavior varied with social class.⁵⁶ Graham failed

⁵²Ruth Elder, "Social Class and Lay Explanation of the Etiology of Arthritis," Journal of Health and Social Behavior 14 (March 1973): 28-38.

⁵³T. Parsons, "Definitions of Health and Illness in the Light of American Values and Social Structure," in Patients, Physicians, and Illness ed. E. G. Jaco (Glencoe: The Free Press, 1958), pp. 234-245.

⁵⁴J. Ross, "Social Class and Medical Care," Journal of Health and Human Behavior 3 (Fall 1962): 35-40.

⁵⁵E. Koos, The Health of Regionville (New York: Columbia University Press, 1954), pp. 146-175.

⁵⁶Ibid., p. 163.

to find these significant differences in illness rates, use of physicians, and hospitalization when he did a similar study several years later. This led him to call for a re-examination of this topic.⁵⁷

Class differences have been noted by other researchers under one set of circumstances but not necessarily under other circumstances. Suchman found that there were no differences in interpreting symptoms as illness when they were severe, continuous, and unalleviated. When symptoms were minor or intermittent, though, he found the class variable to have a marked influence on the person's illness behavior.⁵⁸

Kutner and Gordon reported that both socioeconomic status and education were not related to delay in seeking care for cancer.⁵⁹ Hackett, Cassem, and Raker also studied reasons for delay in seeking help for cancer. They found the relationship to be inversely proportional: the higher the class,

⁵⁷ Saxon Graham, "Sociological Aspects of Health and Illness," in Handbook of Modern Sociology ed. R. E. Faris (Chicago: Rand McNally and Co., 1964), pp. 310-348.

⁵⁸ E. A. Suchman, "Stages of Illness and Medical Care," Journal of Health and Human Behavior 6 (Spring 1965): 114-128; E. A. Suchman, "Social Patterns of Illness and Medical Care," Journal of Health and Human Behavior 6 (Fall 1965): 2-16.

⁵⁹ B. Kutner and G. Gordon, "Seeking Care for Cancer," Journal of Health and Human Behavior 21 (Fall 1971): 171-178.

the less delay.⁶⁰ Their findings highlighted the role of social position on how much people worry about health or things in general. Worry about health was directly related to social position. They explained their findings by comparing them to another study of 100 blue-collar and white-collar responses to coronary heart disease. It was found that patients in lower-socioeconomic categories rarely knew as much about their conditions as their white-collar counterparts and thus worried more.⁶¹ They may have been told less by the nurses and doctors who cared for them, or they may have assimilated less of what was taught; however, there was little question that their tendency to worry was based upon lack of information. Worry diminished when knowledge was provided.⁶²

Waitzkins offers one explanation for the lack of information given to the lower socioeconomic group. He found that physicians tend to communicate differently with patients in different socioeconomic classes. Lower class patients are apt to be given greatly simplified explanations with important aspects only lightly touched, or even omitted, in the belief

⁶⁰Thomas P. Hackett, N. H. Cassem, and John Raker, "Patient Delay in Cancer," New England Journal of Medicine 289 (July 5, 1973): 14-20.

⁶¹Thomas P. Hackett and N. H. Cassem, "Factors Contributing to Delay in Responding to the Signs and Symptoms of Acute MI," American Journal of Cardiology 24 (April 1969): 651-659.

⁶²Ibid.

that the patient cannot comprehend the details.⁶³

Social class influences on personality are basic postulates for social scientists. Extrapolation from these postulates implies that individuals from different social classes have different behavior patterns. Hence, attitudes cause different social classes to observe the world differently.⁶⁴

Class is consistently related to men's values--both for themselves and for their children. Basic to all class relationships is the distinction between self-direction and conformity to external authority. The former is more highly valued by men of higher position, and the latter by men of lower social class position.⁶⁵

All these class relationships can be explained as resulting from cumulative effects of education and occupational position. Education is important because it can foster the intellectual flexibility and breadth of perspective required for self-directed values and orientations. Occupational position is important because it determines the con-

⁶³H. Waitzkins and J. Scoeckle, "The Communication of Information About Illness," Advances in Psychosomatic Medicine 8 (1972): 180-215.

⁶⁴D. Demnison, "Health Behavioral Differences Between Low and Middle Social Class Students," Journal of School Health 34 (October 1964): 731-735.

⁶⁵Kohn and Schooler, "Class, Occupation, and Orientation," pp. 659-678.

ditions that facilitate the exercises of self-direction in work.⁶⁶

Social scientists, in their attempts to determine social class position, have developed several tools. Warner used the Evaluated Participation Scale which called for townspeople to rate their fellows. It was based on the premise that: (1) those in the social system of a community evaluate the participation of others in the system; and, (2) that the members of a community were aware of a ranking system that could be translated into a social class system for the investigator.⁶⁷

Warner also developed the Index of Status Characteristics to measure the socioeconomic levels of a community. His was a multi-item index including occupation, education, source of income, type of dwelling, and residential area. The combined scores of the Scale and the Index yield the score for predicting an individual's social class position. A correlation of 0.97 was obtained between the two instruments.⁶⁸

Hollingshead used a three factor index of education, occupation, and area residence. When he developed the two

⁶⁶Ibid.

⁶⁷W. Lloyd Warner, Marcia Meeker, and Kenneth Bells, Social Class in America: A Manual of Procedure for the Measurement of Social Status (New York: Harper and Brothers, Publishers, 1960), p. 35.

⁶⁸Ibid., p. 168.

factor index, he used education and occupation and indicated a correlation of 0.968 between the two scales.⁶⁹

Kahl and Davis studied the intercorrelations between various multiple factor indexes of social stratification when they compared nineteen indexes of socioeconomic status. They concluded that the two best factors were occupation and education which, when combined, rendered more accurate the dimensions of social position.⁷⁰

Hedge, Seigle, and Ross replicated a study in 1963 of the National Opinion Research Center's 1947 study of prestige positions accorded to ninety occupations by a national sample of the American adult population. Two other studies dating back to 1925 were included in the replication. The replication found only minor changes in prestige of occupation positions. The authors concluded that the structure of occupational prestige is remarkably stable through time.⁷¹

Before 1970, sociologists generally agreed on a five class status structure which included upper, upper middle, lower middle, working, and lower classes. Since the beginning of the seventies, some sociologists are proposing that

⁶⁹Myers and Roberts, Family and Class Dynamics, p. 130.

⁷⁰Joseph A. Jahn and James A. Davis, "A Comparison of Indexes of Socio-Economic Status," American Sociological Review 20 (August 1955): 317-325.

⁷¹Robert Hodge, Paul Seigel, and Peter Ross, "Occupational Prestige in the United States: 1925-1963," American Journal of Sociology 70 (November 1964): 286-302.

this is no longer accurate. They feel that some of the differences between classes are becoming obliterated. Divisions between upper and upper-middle classes and between lower-middle and working classes seem to be less clearly defined.⁷² These speculations have yet to be proven, but they are being expounded more as the decade progresses.

⁷²Richard P. Coleman and Bernice L. Neugarten, Social Status in the City (San Francisco: Jossey Bass, Inc., 1971), p. 278.

CHAPTER III

METHODOLOGY

Type of Research

This is a comparative survey based on a questionnaire investigating the perceptions of patients regarding imminent general abdominal surgery and to compare those perceptions of lower middle, working, and lower class patients.

Setting

This study was conducted in two large general hospitals in a metropolitan city. One was a public general hospital with a bed capacity of 497. It averages 1,120 surgical cases each month, and has 220 surgical beds.

The other was a private general hospital with a bed capacity of 423 and a surgical case load average of 650 cases each month. It has 130 beds for surgical patients.

These hospitals were chosen to obtain a representative cross-section of the population of lower middle, working, and lower social classes.

Sample Population

All persons admitted to the general surgery wards from May 26, 1974 to February 30, 1975 who met the specified criteria constituted the population of this study. The method of sampling

was one of convenience; all those patients who were available when the investigator was on the units who met the criteria. The specific criteria were as follows:

1. Social class: They must be members of either the lower middle, working, or lower class position as specified by Hollingshead's Two Factor Index of Social Position.
2. Language: They must be English-speaking persons who are sufficiently literate to read the Patients' Perception Scale. This criterion was imposed to insure adequate communication between the investigator and the patient.
3. Age: They must have attained their twenty-first birthday and have not yet reached their sixtieth birthday. Persons within this age group are involved in the active responsibilities of life.
4. Type of surgery: They must be scheduled for the general abdominal surgeries of cholecystectomy, gastrectomy, or herniorrhaphy.
5. Diagnosis: They must not have a diagnosis or suspected diagnosis of malignancy.
6. Prognosis: They must not have a poor prognosis.
7. Previous surgeries: They must not have had more than three previous operations.
8. Participation: They must verbally agree to participate in the study.

All patients who met the criteria were admitted to the study until the quota of ten individuals in each social class was filled.

Tool for Measurement

A questionnaire with a Likert-type scale was selected as the method to gather data pertinent to the perceptions of patients to general abdominal surgery. The questionnaire was designed by Palmer in 1963 for a similar study.¹ Written permission was obtained from Palmer for the use of the tool.

Statements in the tool were developed to measure such categories of perceptions as: (1) confidence in the ability of the family to maintain itself, (2) faith in God, (3) skill and competence of doctor, hospital, and staff, (4) body integrity, (5) acceptance of the need for surgery, (6) financial security, (7) understanding, acceptance, and support by others, (8) dependency-independency relationships, (9) postoperative patterns of living, (10) expectations about the operation, (11) self-awareness, (12) anesthesia, and (13) painful procedures.²

¹Irene S. Palmer, Perceptions of Patients to Imminent General Surgery: A Comparative Analysis of the Expressed Perceptions of Patients Between the Ages of Twenty-one and Sixty Years of Age to Cholecystectomy, Gastrectomy, and Herniorrhaphy (Michigan: University Microfilms, Inc., 1963), p. 154.

²Irene S. Palmer, "The Development of a Measuring Device: Measuring Patients' Perceptions Toward Impending Surgery," Nursing Research 14 (Spring 1965): 100-105.

All of the statements were constructed to be positively toned in order to avoid contributing to the anxiety and apprehension of the patients. The reliability and validity of the Scale were both adequately tested by Palmer in 1963 before she began her study.³

Each item on the scale was scored from five to one, with the following weights for each check: five points for strongly agree, four points for agree, three points for undecided, two points for disagree, and one point for strongly disagree. The score for the individual patient was the sum of the weights on his scale.⁴ The total summated score was recorded in the appropriate place on the Patient Data Form.⁵ This form was a page on which pertinent information about the patient could be recorded. It included such information as age, sex, occupation, education, type of surgery, and calculated social class. A copy of the Patient Data Form is found in Appendix B, page 65. The Patient Perception Scale is found in Appendix C, page 66.

Data Collection

Because each hospital performed general surgery on Monday through Friday, data were collected every Sunday through

³Ibid.

⁴Palmer, Perceptions of Patients, p. 68.

⁵Palmer, The Development of a Measuring Device, p. 100.

Thursday. Surgery schedules were printed at each hospital on the afternoon of the day prior to the expected day of the operation. Every patient posted for the general abdominal surgeries of cholecystectomy, gastrectomy, or herniorrhaphy was screened for possible inclusion in the study. The chart of each possible candidate was then reviewed for medical and personal data. This was done to eliminate those patients who did not meet the stated criteria. Upon selection of a patient for inclusion in the study, the data necessary to identify the subject were recorded on the Patient Data Form. (See Appendix B, page 65.)

Each patient was then approached and asked if he would be willing to answer the questionnaire concerning how he felt about having surgery. He was assured that the information would be confidential. The investigator wore a white laboratory coat and always identified herself as a nurse-student from Texas Woman's University.

The next step in the collection of data was to determine the educational level and occupation of the subject in order to ascertain his social class position. If a woman stated that her occupation was that of a housewife, the education and occupation of her husband were used to ascertain her social class position.

After obtaining the data required to ascribe social class membership to the subjects, the patient was then given the Patients' Perception Scale with instructions for its use. (See

Appendix C, page 66.) A lap board and pencil were provided. The investigator read and explained the instructions to the patient even though the directions were written on the instrument. While the patient was completing the questionnaire, the investigator remained in the room to prevent interruptions and communication with others and to insure that all questions were answered.

Data Analysis

Patients in this study were placed in the appropriate social class with the use of Hollingshead's Two Factor Index of Social Position. (See Appendix A, page 62.) This tool was developed by Hollingshead to meet the need for an objective, easily applicable procedure to estimate the positions individuals occupy in the status structure of their society.⁶ Education and occupation are the criteria that form the basis of this scale. It should be noted that the Hollingshead measure is an "operational definition" of social class and has been used extensively by other investigators.⁷

⁶August B. Hollingshead, Two Factor Index of Social Position (New Haven, Connecticut: printed privately, 1957), p. 2.

⁷M. L. Kohn and C. Schooler, "Class, Occupation, and Orientation," American Sociological Review 34 (October 1969): 659-678; T. Tissue, "Downward Mobility in Old Age," Social Problems 18 (Summer 1970): 67-77; R. J. Turner and H. O. Wagenfeld, "Occupational Mobility and Schizophrenia: An Assessment of the Social Causation and Social Selection Hypothesis," American Sociological Review 32 (February 1967): 104-113.

In a traditional sociological sense, social classes are collectivities of persons that are differentiated from one another primarily by wealth, style of life, and power. Place of residence, income, cultural values, social behavior, and other factors are therefore important criteria. However, since these variables are often difficult to measure and blend into some vertical scale, many researchers rely on the Hollingshead Index. Its combined scores for education and occupation operationalize the concept of social class in terms of the characteristics that appear most relevant in our society.⁸ The score representative of the individual's index of social position and indicative of his social class membership was recorded on each patient's Data Form.

Each question on the Patients' Perception Scale was scored from five to one, with the following score for each: five points for strongly agree, four points for agree, three points for undecided, two points for disagree, and one point for strongly disagree. The total number of points for each patient was recorded on his Data Form. The maximum attainable score was 230, while the minimum possible score was forty-six. The mid point on the scale was 138.

In order to facilitate data organization, the factors of

⁸R. M. Weinstein and N. Brill, "Social Class and Patients' Perceptions of Mental Illness," Psychiatric Quarterly 45 (January 1971): 34-44.

social class, sex, and age were symbolized. The variable of social class position, represented by the letter A, had three sections: A_1 was used to denote the lower middle class; A_2 stood for the working class; and A_3 corresponded to the lower class. Sex, which had two sections, was the second factor and was indicated by the letter B. B_1 stood for men and B_2 indicated women. The final variable of age, symbolized by the letter C, had four sections: C_1 included people twenty-one through thirty years of age; C_2 represented persons who were thirty-one through forty years old; C_3 denoted subjects who were forty-one through fifty years of age; and, C_4 indicated patients who were fifty-one to sixty years old.

The analysis of variance provides a flexible procedure for determining the factors that influence the variation from the mean of several groups of observations. The test of significance which is used is based upon the distribution of F. Three assumptions must be met for the analysis of variance to be used successfully. The data used in the calculations must come from independent random samples, and from normally distributed and equally variable populations.⁹ The major reason for using the analysis of variance is that it can be partitioned into its component parts in a fashion that permits

⁹John T. Roscoe, Fundamental Research Statistics for the Behavioral Sciences (New York: Holt, Rinehart and Winston, Inc., 1969), p. 231.

the investigator to identify these as sources of variation.

Each variable in the data for this study - social class, sex, and age -- was grouped into sets so that each of the sum of the squares for the respective variable could be computed. The within group and between group variations were computed from these divisions.

The mean square was obtained by dividing each sum of the squares by its respective degree of freedom. The value of F was determined by dividing the mean square within by the mean square between. The F value, once obtained, was found in the distribution table. When the observed value of F was greater than the tabled value at the 5 percent level of significance, the means of the groups were considered to differ significantly among themselves.

When the differences among the individual group means were found to be significant, the Scheffé test was applied to determine whether the individual means differed significantly. The Scheffé test determines the smallest significant value of the differences between the individual means.¹⁰ The results of the above procedures for the collection and treatment of data are recorded in the following chapter.

¹⁰David J. Fox, Fundamentals of Research in Nursing (New York: Appleton-Century-Crofts, 1966), p. 144.

CHAPTER IV

ANALYSIS OF DATA

Introduction

The purpose of this study was to compare the expressed perceptions of lower-middle, working and lower social class individuals to general abdominal surgery. Thirty pre-operative patients, ten from each selected social class, were interviewed. A Likert type questionnaire concerning perceptions of the surgical experience was administered to each patient.

General Description of the Sample

The study sample consisted of thirty preoperative patients, between the ages of twenty-three and sixty, with a mean age of forty-three. Twenty-six were scheduled for cholecystectomy, three for abdominal hernia repair, and one for gastric resection. Eight patients were male, and twenty-two were female. (See Table 1.)

Treatment of Data

The questionnaire used to ascertain the expressed perceptions of the surgical experience had a potential score range of from forty-six to 230. The minimum score indicated total disagreement with all statements, and the maximum score indicated

TABLE I
DEMOGRAPHIC DATA ON SAMPLE POPULATION

Social Class	Age	Sex	Surgery	Score
V	23	F	Cholecystectomy	210
V	39	F	Cholecystectomy	169
V	30	F	Cholecystectomy	216
V	31	F	Cholecystectomy	213
V	52	F	Cholecystectomy	192
V	39	F	Cholecystectomy	221
V	57	F	Cholecystectomy	228
V	24	M	Cholecystectomy	188
V	25	M	Cholecystectomy	153
V	58	M	Cholecystectomy	230
IV	48	F	Ventral Hernia	114
IV	47	F	Hiatal Hernia	179
IV	43	F	Cholecystectomy	185
IV	40	F	Cholecystectomy	162
IV	48	F	Cholecystectomy	162
IV	53	F	Cholecystectomy	173
IV	46	F	Cholecystectomy	172
IV	52	F	Cholecystectomy	158
IV	44	F	Cholecystectomy	205
IV	29	M	Cholecystectomy	129
III	60	M	Gastric Resection	211
III	56	F	Hiatal Hernia	217
III	38	F	Cholecystectomy	157
III	52	F	Cholecystectomy	194
III	52	F	Cholecystectomy	192
III	39	F	Cholecystectomy	179
III	52	F	Cholecystectomy	216
III	42	M	Cholecystectomy	194
III	36	M	Cholecystectomy	192
III	47	M	Cholecystectomy	148

total agreement. The mid-point for the scale was 138.

The obtained range of scores was 114 to 230. The low score was obtained from a middle-aged (41-50 years) working class female while the highest score was of an older (51-60 years) lower class male. All but two scores were on the positive side of the scale. The mean score for all three groups was 185.3. This high mean indicates that the subjects were in general agreement with the statements on the Patients' Perception Scale. The statements were all positively toned and worded.

Relationship between perception and specific factors

The scores from the questionnaires were compiled and subjected to the analysis of variance to determine if a significant difference existed between the means of specific factors.

The first null hypothesis to be tested was the following: There is no difference in the perceptions of subjects toward imminent general surgery according to their social class position. The scores were grouped according to their respective social class. The mean score for the lower middle class was 190. The mean for the working class was 163.9 and for the lower class, the mean was 202. (See Table 2.)

TABLE 2

MEAN SCORES FOR SOCIAL CLASSES

Social Class	Mean Scores
Class III	190
Class IV	163.9
Class V	202

Factorial analysis of variance of the scores was carried out. A significant difference at the 5 percent ($p < 0.05$) level between the means of the scores in each social group was observed. The null hypothesis was rejected. (See Table 3.)

TABLE 3

SUMMARY TABLE FOR THE ANALYSIS OF VARIANCE

Source of Variation	Sum of Squares	d.f.	Mean Square	F.	p.
Between Groups	7589.4	2	3794.7	5.99	<0.05
Within Groups	17108.9	27	633.7		
Total	24698.3				

Since the result of an analysis of variance was significant at a 5 percent ($p < 0.05$) level, a Scheffé test was done to determine which differences between group means were significant.

The Scheffé test was significant at the 5 percent ($p < 0.05$) level for Class IV and V. It was also significant when Class III and V were combined and tested against Class IV. This would appear to indicate a significant difference in the perceptions to imminent general surgery in the working class as compared to the lower middle and lower social classes. (See Table 4.)

TABLE 4
INDIVIDUAL CLASS COMPARISONS WITH THE SCHEFFE TEST

Class *	Computed F	p	Null Hypotheses
$A_1:A_2$	2.69	$p > 0.05$	reject
$A_1:A_3$	0.06	$p > 0.05$	reject
$A_2:A_3$	5.73	$p < 0.05$	retain

* A_1 - lower middle class
 A_2 - working class
 A_3 - lower class

This finding differs from that of Palmer who found no difference in class perceptions toward imminent general surgery.¹

The second null hypothesis tested was: No difference in perception of imminent general surgery occurs because of age difference. The sample was divided into four age groups. The first group included ages twenty-one to thirty; the second group was from thirty-one to forty; the third was from forty-one to fifty; and, the fourth group included ages fifty-one to sixty. The means for the four age groups ranged from 169.9 to 201.1. The lowest was in the third group, and the highest being in the last age group. (See Table 5.)

¹Irene S. Palmer, Perceptions of Patients to Imminent General Surgery: A Comparative Analysis of the Expressed Perceptions of Patients Between the Ages of Twenty-one and Sixty Years of Age to Cholecystectomy, Gastrectomy, and Herniorrhaphy (Michigan: University Microfilms, Inc., 1963), p. 104.

TABLE 5
MEANS ORGANIZED BY AGE GROUPS

Age	Mean
21-30	179.2
31-40	184.7
41-50	169.9
51-60	201.1

Factorial analysis of variance of the scores was carried out to determine if a significant difference between the means of each age group existed. Results indicated no significant difference to exist at the 5 percent ($p > 0.05$) level. The null hypothesis was accepted. (See Table 6.)

TABLE 6
SUMMARY TABLE FOR THE ANALYSIS OF VARIANCE

Source of Variation	Sum of Squares	d.f.	Mean Squares	F	p.
Between groups	4588.3	3	1529.4	1.98	>0.05
Within Groups	20110	26	773.5		
Total	24698.3				

This finding differs from that of Palmer. She found a significant difference between the perceptions of the youngest group and the oldest group.²

The third null hypothesis to be tested was: No difference in the perception of imminent general surgery exists between male and female subjects.

The mean scores for both sexes fell within the positive range. Males averaged a score of 187 while female scores averaged slightly lower at 180.6.

The scores were submitted to factorial analysis of variance. The means were found not to differ significantly at the 5 percent ($p > 0.05$) level and, thus, the null hypothesis was retained. (See Table 7.)

TABLE 7
SUMMARY TABLE FOR THE ANALYSIS OF VARIANCE

Source of Variation	Sum of Squares	d.f.	Mean Squares	F	p.
Between Groups	238.4	1	238.4	0.027	>0.05
Within Groups	24459.9	28	873.6		
Total	24698.3				

This finding concurred with that of Palmer.³

²Palmer, Perceptions of Patients, p. 106.

³Ibid., p. 102.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to compare the expressed perceptions of lower middle, working, and lower class individuals to general abdominal surgery. It was the intent of the investigator to broaden the knowledge of how a patient perceives his surgical experience and, thus, enable the nurse to be better able to prepare the patient for that experience.

The study sample consisted of thirty patients, ten from each social class, who were scheduled for the operative procedures of cholecystectomy, gastrectomy, or abdominal herniorrhaphy. Specific criteria were used for selection of subjects such as age between twenty and sixty, good prognosis, and no more than three previous surgeries.

Perceptions were measured on a scale called the Patients' Perception Scale. This is an instrument developed and validated in 1963 by Palmer for a similar study.¹ The scores from the Patient's Perception Scale were accepted as represent-

¹Irene S. Palmer, Perceptions of Patients to Imminent General Surgery: A Comparative Analysis of the Expressed Perceptions of Patients Between the Ages of Twenty-one and Sixty Years of Age to Cholecystectomy, Gastrectomy, and Herniorrhaphy (Michigan: University Microfilms, Inc., 1963), p. 48.

ative of the individual perceptions of patients to impending general surgery. These scores were used as the data for analysis.

The hypothesis tested was that there are no significant differences in the way adults between the ages of twenty-one and sixty years of age perceive impending general abdominal surgery according to their membership in the lower middle, working, or lower social classes. The information was obtained through the Patients' Perception Scale administered to patients scheduled to undergo general abdominal surgery. The analysis of data obtained from the scores indicated a significant difference does exist at the 5 percent ($p < 0.05$) level between mean scores of the subjects in this study. A comparison of individual group means indicated the significant difference to exist between the working class as opposed to the lower-middle or lower classes. The null hypothesis was rejected.

Although no hypothesis was formulated concerning the age or the sex of the patients, these data were analyzed for significant differences in means relating to these factors. Data revealed no significant difference of perceptions regarding impending general surgery related to these factors.

The findings of this study did not correspond to the findings of a similar study done by Palmer in 1963. Her study revealed no difference in perception related to social class

position, but she did note a significant difference related to age groups.²

Conclusions

Since the emphasis today in nursing is to care for the patient as a whole--physically and psychologically-- it is important that the nurse recognizes what an experience means to a patient and his family. Knowledge of how class structure affects those perceptions should play a part in the planning of care.

If further research supports the findings of this study, that the working class views the surgical experience less positively than the lower middle and lower classes, then this fact should be recognized when preoperative preparation of patients occurs.

Because the results of this study do not corroborate the results of a similar study done in 1963, it is now important that these studies be replicated. It is possible that time has changed the expressed perceptions of different social classes. It could be that the geographical difference of the study population has affected the results. The size of the sample was such that potential error was high. The results of the study are such, though, that further research on the subject should be encouraged.

²Ibid.

Recommendations

The following recommendations were made after analysis of the data:

1. Future studies using larger numbers of subjects should be done to corroborate or reject the findings of this investigation, especially because the results of this study are in conflict with the only previous study.
2. Future studies including the social classes excluded from this study should be done.
3. The Patients' Perception Scale should be altered to be negatively toned, because the way an instrument is worded could affect the answers.
4. The relationship between a person's past hospital experience and his present preoperative perceptions should be investigated.
5. An instrument should be developed to ascertain other factors that might influence preoperative perceptions of patients.

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APPENDIX A

OCCUPATIONAL AND EDUCATIONAL SCALES FOR HOLLINGSHEAD'S TWO FACTOR INDEX OF SOCIAL POSITION¹

The Occupational Scale

The Occupational Scale used in the Index of Social Position is a modification of the Alba Edwards method of grouping occupations into socio-economic stratifications used by the United States Bureau of the Census. It is based upon the assumption that certain occupations are more highly valued in society than others. Seven positions on a hierarchical scale are used:

1. executives and proprietors of large concerns and major professionals;
2. managers and proprietors of medium-sized businesses and lesser professionals;
3. administrative personnel of large concerns, owners of small, independent businesses and semi-professionals;

¹August B. Hollingshead, Two Factor Index of Social Position (New Haven, Connecticut: printed privately, 1957), p. 2.

4. owners of little businesses, clerical and sales workers and technicians;
5. skilled workers;
6. semi-skilled workers;
7. unskilled workers.

The Educational Scale

The assumption underlying the use of the educational scale is that those persons having comparable education are likely to share comparable tastes and attitudes and are inclined to demonstrate comparable behavior patterns. The seven positions are:

1. Graduate professional training. (Persons who completed a recognized course which led to the receipt of a graduate degree were given the score of 1.)
2. Standard college or university graduation. (All individuals who had completed a four-year college or university course leading to a recognized college degree were assigned the same score. No differentiation was made between state universities or private colleges.)
3. Partial college training. (Individuals who had completed at least one year but not a full college course were assigned this position.)
4. High school graduation. (All secondary school graduates whether from a private preparatory school,

public high school, trade school or parochial high school were given this score.)

5. Partial high school. (Individuals who had completed the tenth or eleventh grades but had not completed high school were given this score.)
6. Junior high school. (Individuals who had completed the seventh grade through the ninth grade were given this position.)
7. Less than seven years of school. (Individuals who had not completed the seventh grade were given the same scores irrespective of the amount of education they had received.)

Each factor is weighed. The weight of the occupational factor is seven. The factor weight for education is four. The individual scores for social position are computed by multiplying the scale score by the factor weight for each factor. The resultant score represents the Index of Social Position. The range for these scores is:

<u>Social Class</u>	<u>Range of Derived Scores</u>
I	11 - 17
II	18 - 27
III	28 - 43
IV	44 - 60
V	61 - 77

APPENDIX B

Patient Data Form¹

Sex: M ___ F ___ Birth Date: Month ___ Day ___ Year ___

Operation Scheduled: _____ Diagnosis _____

Is patient in good health except for the condition for which surgery is planned?

Yes ___ No ___ If no, elaborate: _____

No. of times operated on before: ___ Type Anesthesia _____

Race: W ___ N ___ Other ___ Religion: C ___ P ___ J ___ Other ___

Education: Circle years completed: 0; 1-6; 7-9; 10-11; 12;
College: 1; 2; 3; 4; Graduate work _____

Occupation: Specify: _____

If unemployed, what was last job held _____

If housewife and not employed outside home, what is spouse's occupation: _____

If never employed, what was father's occupation: _____

If never employed, and father not resident of household, what is occupation of head of household: _____

Index of Social Position:		Social Class	Derived Scores
Scale x Factor Weight =	Score	III	28-43
___ x 4 =	Educational Score	IV	44-60
___ x 7 =	Occupational Score	V	61-77

Educational Score plus Occupational Score - _____ Derived Score

- _____ Social Class

Patients' Perception Scale: _____ Total Score

Hospital Code No. _____ Date _____

¹Irene S. Palmer, Perceptions of Patients to Imminent General Surgery: A Comparative Analysis of the Expressed Perceptions of Patients Between the Ages of Twenty-one and Sixty Years of Age to Cholecystectomy, Gastrectomy, and Herniorrhaphy (Michigan: University Microfilms, Inc., 1963), p. 153.

APPENDIX C

Patients' Perception Scale¹

Directions:

The following pages contain some statements indicating how patients feel about being operated upon. There are no right or wrong answers to these statements. Let your own personal feelings determine your answers. Please answer every statement. Please check whether you strongly agree, agree, are undecided, disagree, or strongly disagree with each statement.

Checking a statement strongly agree means that you definitely and emphatically agree with the statement. You are really sure of your agreement with it.

If you definitely disagree and have no doubt about your disagreement with the statement, check strongly disagree.

If you are not really sure about how you feel about a statement, check undecided.

If you agree with the statement generally, but are not completely emphatic and very sure about it, check agree.

If you disagree with the statement, but are not really emphatic in your disagreement with it, check disagree.

Example:

Surgical operations have improved so much in the past several years.

Strongly agree____, Agree____, Undecided____, Disagree____, Strongly disagree____.

Checking this statement strongly agree means that you are very sure that surgical operations have improved a great deal in the past several years. If you definitely and emphatically believe that surgical operations have not improved much in the past several years, you would check strongly disagree.

¹Irene S. Palmer, Perceptions of Patients to Imminent General Surgery: A Comparative Analysis of the Expressed Perceptions of Patients Between the Ages of Twenty-one and Sixty Years of Age to Cholecystectomy, Gastrectomy, and Herniorrhaphy (Michigan: University Microfilms, Inc., 1963), p. 154.

1. Soon I am going to be able to do all the things I used to do.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
2. The people who are closest to me in my family can take this in their stride.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
3. I can be up and doing things for myself in a few days.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
4. Surgery is a quick way to get well.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
5. The staff help make people comfortable when they have pain.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
6. Surgery is much safer today than it was in my parents' time.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
7. The thought of having an incision does not upset me.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
8. My immediate family knows how to manage while I am in the hospital.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
9. Hospitals are the best place to be when you are sick.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
10. With God's help, this operation is going to restore my good health.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
11. I know what is going to happen to me.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.

12. Money is of little importance at a time like this.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
13. The pain after the operation is not going to amount to
much.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
14. My immediate family are able to take care of themselves
while I am in the hospital.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
15. Even though I am being operated upon, there are some
things I am able to do for myself.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
16. If you have lots of faith in God, being operated on need
not worry you.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
17. Medical science takes the chance out of an operation today.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
18. Surgery is necessary to my future health and well-being.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
19. I am doing everything the way the doctors and nurses want.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
20. Now is the best possible time for this surgery.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
21. The people closest to me understand how I feel about having
this operation.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.
22. What I might say coming out of the anesthesia does not
concern me.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree____.

23. I am receiving the best care possible.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
24. This operation is going to remove my source of discomfort.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
25. It is a relief to me that the entire situation is out of
my hands.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
26. The people who are taking care of me are a great source of
strength to me.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
27. Incisions are not very noticeable these days.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
28. At times like this I am glad to depend on other people.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
29. This experience is like an adventure to me.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
30. I have confidence in the skill of the hospital staff.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
31. The people who are caring for me give me great courage.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
32. There is no need to worry about being operated upon.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
33. Pain can be overcome in a situation like this.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.
34. Modern drugs make people comfortable.
Strongly agree____, Agree____, Undecided____, Disagree____,
Strongly disagree_____.

35. Soon I can take up where I left off.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
36. Most of my questions about the operation have been answered.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
37. I am being as little trouble as possible for the people who
are taking care of me.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
38. A scar on the abdomen does not matter.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
39. This operation creates no problem for the people closest
to me.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
40. With faith in God, everything turns out well.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
41. I can take what goes on before and after the operation.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
42. We get wonderful care in our hospitals today.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
43. It is a relief that I have no more decisions to make.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
44. The people who are taking care of me know how I feel about
having this operation.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
45. With prayers, all turns out well.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.
46. I can lead my usual life after I am over this operation.
Strongly agree___, Agree___, Undecided___, Disagree___,
Strongly disagree___.